Preventing suicide: a call to action

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José Bertolote has provided us with a stimulating overview of the many issues swirling around the application of prevention concepts and techniques to the problem of suicide and suicidal behaviors. He asks us to stop and think about how we got to where we are, how comfortable we are about where we are, where we need to go, and what it might take to allow us to move forward in a scientific and humanistic manner. He couches his perspectives of the international "problem of suicide" – for, in fact, it is a problem for all nations – as a health issue, grounded "somewhere between public health and psychiatry". Bertolote sees suicide as a public health problem which has to be understood through the double lens of psychiatry – as both the consequence of brain disorders and as a manifestation of psychosocial dysfunctions. I commend his synthesis of many public health, mental health, and socioeconomic contributions to approaching this major international health problem.

Clearly, we cannot begin to apply the emerging list of prevention techniques and interventions to the problem of suicide until we clarify terms and establish definitions. My colleagues and I are working on a revision of the nomenclature we first proposed in 1996 (1). Meanwhile we are left with a mixed bag of thoughts, emotions, and actions that constitute the "suicidal process" and that serve as targets for our proposed interventions.

There is little scientific debate or clinical disagreement that the following constitute key processes or expressions of the suicidal process: suicide ideation, suicide intent, suicide gestures, suicide attempts/deliberate self-harm, and suicide completions. Confusion remains about what is meant by saying that someone is "suicidal" or expressing "suicidality". What constitutes "suicidal behaviors"? Does ideation fall within the domain of "behaviors"? The debates continue about defining "intent", "motivation" and "lethality" (is it sufficient that it only be in the eye of the beholder?). As the Editor-in-Chief of Suicide and Life-Threatening Behavior, the official journal of the American Association of Suicidology, I can assure you that there are no standard research definitions being used for many terms that we associate with self-destructive or self-injurious behaviors. I do not believe that suicide prevention can achieve any meaningful successes until we clarify some key relationships, ascribe to thoughts (ideations), emotions (intent, wishes), and behaviors (deliberate self-harm, attempts, completions) the appropriate risk factors, protective factors, and warning signs, and construct valid profiles of populations at risk.

For example, most suicidologists would agree that suicidal planning is a key variable to elicit and evaluate as part of a clinical assessment for imminent risk for suicide. Most preventionists would want to intervene before suicidal planning emerges or before planning "goes too far". Yet we are not consistent in how we study or categorize "planning". Is it an ideation/thought or a behavior/action? Could it be both? If it remains at the conceptual level, is it potentially less "lethal" than if it takes the form of an action to acquire a lethal means to die? We still do not know enough about the causative, interactive and facilitative relationships between ideation, intent, planning and action. As Bertolote asks, what are we trying to do and how do we measure it? He points out that there is a lack of precision in both objectives and indicators, which makes true assessment a difficult task.

Prevention is based on prediction. Can we predict the course of suicidal ideation? Can we predict the course of suicidal intention? Where is the logical scientific chain of causation saying that attempts, let alone completions, will be reduced if we mount suicide prevention campaigns addressing the eradication, reduction, modification or amelioration of suicidal ideation? Can we prevent suicidal ideation? If 13.5% of the general population in the US have suicidal ideation, can a valid scientific argument be made for a national prevention campaign to address suicidal ideation (2)? Would this be a valuable international effort in and of itself? Or, given limited resources, would it not be better to develop a two-pronged approach centering around suicide attempts/deliberate self-harm behaviors (one prong being to prevent the onset of self-destructive behaviors by identifying those most at risk for their expression and intervening both clinically and from a public health perspective; the second prong being to enroll all those already identified as expressing such behavior in a formal assessment to determine whether further intervention is warranted and providing it when indicated, with the goal of reducing the 10% lifetime mortality associated with this behavior)?

Given that most research projects have relatively short timeframes (3-5 years), what are to be our endpoints to measure whether we have been successful in intervening at one point in the proposed "continuum" to change the emergence (re-emergence?) of a pathological thought (ideation), emotion, or "action" (behavior) at some later time? And can we hope to "immunize" these at-risk individuals from all the stresses and strains in their lifetime which might contribute to the initiation of suicidal thoughts, emotions, and actions (3)? Until we all agree on

how to measure those proximal and distal targets of our interventions, we will continue to be unclear about causal links and cause-and-effect relationships.

So, what do we know? We do, indeed, know a lot. We know that past behavior predicts future behavior. We know that past exposure to suicidal thoughts/emotions/actions predicts future "suicidality", including ideation, intent, attempts/deliberate self-harm, and completions. We know that mental disorders of all sorts (including substance abuse) and some physical disorders contribute to the expression of "suicidal behaviors" (and suicidal ideation and intent as well). In fact, we know much more about risk factors than we do about protective factors. We are much better at categorizing risk factors into different groupings (perpetuating/predisposing/precipitating; environmental/biological/psychological) than we are able to link some protective factors to our understanding of the "suicidal process" (4). Surely much more research attention needs to be placed on identifying protective factors and creatively designing interventions to ensure their presence in a developmental context (5).

Where do I see the challenges? In addition to the ones already mentioned (nomenclature and classification; setting measurable outcomes with reasonable timeframes), I would add that some serious work needs to be done on the integration of prevention theories and concepts to the problem of suicide (6). Some interventions that we have are short-term and are applicable in acute, crisis-oriented settings. Others are long-term and are not immediately measurable. We are amassing an armamentarium of "things to try", but we still lack the prevention framework to measure their effectiveness and efficacy. As Bertolote has identified, there are a number of conceptual models of public health interventions. Those currently in vogue include: Gordon's Universal/Selective/Indicated; Haddon's Injury Control Model (Pre-injury, Injury, Post-injury); the public health triad of Primary/Secondary/Tertiary; and the alternative of Prevention/Intervention/Postvention (7). The conceptual model for the public health approach to the prevention of infectious diseases may well differ from the approach to injury prevention and may yet differ from the approach needed for the prevention of elements within the "suicidal spectrum" (ideation, intent, planning, gestures, attempts, deliberate self-harm, completions).

Bertolote is calling for a bold integration of public health, mental health, sociology, political will, economics, religion, etc., in order to mount a true campaign to prevent suicide globally. He is calling for cross-fertilization, cross-training, and the integration of purpose, message, theory, concepts, and outcomes. I am ready to join this effort. I ask that you consider joining as well.

References

1. O'Carroll PW, Berman AL, Maris RW et al. Beyond the tower of babel: a nomenclature for suicidology. Suicide Life Threat Behav 1996;26:237-52.
2. Kessler RC, Borges G, Walters EE. Prevalence of and risk for lifetime suicide attempts in the national comorbidity survey. Arch Gen Psychiatry 1999:56: 617-26.
3. Mann JJ, Waternaux C, Haas GL et al. Toward a clinical model of suicidal behavior in psychiatric patients. Am J Psychiatry 1999;156:181-9.
4. Silverman MM, Felner RD. The place of suicide prevention in the spectrum of intervention: definitions of critical terms and constructs. Suicide Life Threat Behav 1995;25:71-82.
5. US Public Health Service. National strategy for suicide prevention: goals and objectives for action. Rockville: US Department of Health and Human Services, 2001.
6. Felner RD, Felner TY, Silverman MM. Prevention in mental health and social intervention: conceptual and methodological issues in the evolution of the science and practice of prevention. In: Rapaport J, Seidman E (eds). Handbook of community psychology. New York: Plenum Press, 2000:9-42.
7. Silverman MM. Theories of primary prevention and health promotion. In: Gullotta TP, Bloom M (eds). The encyclopedia of primary prevention and health promotion. New York: Kluwer/Plenum, 2003:27-42.